Real Possibilities

February 26, 2013

The Honorable Kevin Brady
Chairman
Ways & Means Subcommittee on Health
Washington, D.C. 20515

The Honorable Jim McDermott
Ranking Member
Ways & Means Subcommittee on Health
Washington, D.C. 20515

Dear Chairman Brady and Ranking Member McDermott:

On behalf of AARP's 37 million members and the millions of Americans with Medicare, thank you for holding a hearing to examine traditional Medicare's benefit design. Medicare continues to play a vital role in the health and financial security of older Americans. We have long recognized the need to strengthen and improve the program and appreciate that the committee is considering ways to do so. As Congress considers various proposals, we urge you to examine all the potential ramifications on beneficiary out-of-pocket spending, access to needed care, and total costs to the health care system.

As you know, the current Medicare fee-for-service (FFS) benefit structure requires beneficiaries to meet separate annual deductibles for Part A (hospital insurance) and Part B (medical insurance, including physician visits) services. For 2013, the Part A deductible is $1,184 and the Part B deductible is $147 respectively. After meeting the deductibles, a beneficiary faces wide variation in coinsurance, depending on the type of service he or she receives. For example, in Part A, a beneficiary pays for a daily rate if she requires more than 60 days in an inpatient hospital, and she pays a daily coinsurance starting on the 21st day in a skilled nursing facility (SNF). In Part B, a beneficiary pays for 20 percent of the cost of care except for home health services and some preventative care services, which are fully paid by Medicare.

There are notable gaps in current Medicare benefits, including the lack of a catastrophic cap and coverage for certain essential health benefits. In recent years, the creation of the Medicare Part D drug benefit in 2006 and the phasing out of the coverage gap, or "doughnut hole", in Part D – as required by the Affordable Care Act – have been major improvements. Yet, even with these improvements, out-of-pocket costs still remain a great burden for many Medicare beneficiaries. Analysis by AARP's Public Policy Institute finds that at least 50 percent of Medicare beneficiaries – who have incomes of roughly $20,000 – spent $3,100 on health care expenses, or nearly 17 percent of income, in 2007 (the most recent year for which Medicare Current Beneficiary Survey data were available). Ten percent of beneficiaries spend over $7,800 on health care costs.[1] The report also finds that out-of-pocket spending is higher for older and poorer beneficiaries: spending increases to over 20 percent of their income on health care.

[1] C Noel-Miller, "Medicare Beneficiaries' Out-of-Pocket Spending for Health Care", AARP Public Policy Institute, Washington, DC, May 2012. Includes spending for Medicare and supplemental premiums, and for medical services and some long-term services and supports. http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/medicare-beneficiaries-out-of-pocket-spending-AARP-ppi-health.pdf

Without an out-of-pocket cap, the traditional Medicare program currently leaves beneficiaries at risk for significant cost-sharing if they become seriously ill or need to manage chronic health conditions. No other public or private health insurance plan imposes the same level of risk on their participants: these plans generally limit the amount of cost-sharing that participants have to pay in a year or a lifetime. As a consequence, most Medicare beneficiaries rely upon other supplemental insurance to avoid the potential risk of significant out-of-pocket costs (e.g. employer-provided retiree health and Medigap) or rely on Medicaid. Not all beneficiaries have supplemental insurance coverage, however. About 4 million beneficiaries (8%) have no additional coverage, and potentially face significant health care expenses should they become seriously ill.

Since the enactment of the Medicare program, health care has changed significantly. Prescription drug treatments have grown substantially in importance, and technology has provided a range of new treatment interventions. Further, more treatments are provided on an outpatient basis and the cost of health care has grown dramatically. Reexamining the Medicare benefit package to evaluate options to better serve the health care needs of beneficiaries, maintain the affordability of the program, and improve program efficiency is an important goal.

In exploring any Medicare redesign, AARP believes that it is essential to look at any proposed changes from the perspective of beneficiaries, not just from the perspective of a budget score. Most beneficiaries already struggle to make ends meet, and are particularly sensitive to the high cost of health care and prescription drugs. An examination of Medicare redesign must take into account the economic status of seniors, as well as evaluate how benefit changes will interact with other potential changes to the Medicare program.

In addition, any redesign of Medicare cost-sharing will potentially affect various groups of Medicare beneficiaries differently. All too often, proposals are evaluated as if all beneficiaries are identical. In fact, they are not and they will be affected differentially. The impact will depend on the types of services they use, the intensity of their use, whether and what type of supplemental coverage they have, and their income. Those without supplemental coverage will be most directly impacted by increases in cost sharing. Research shows that individuals, particularly those who are sicker and poorer, react to higher cost sharing by avoiding or delaying use of health care services, including necessary care. In particular, this would apply to services that currently require no coinsurance or limited coinsurance, such as inpatient hospital services or hospice. The avoidance of needed care could lead to a faster or more serious decline in health, which not only has adverse consequences for the beneficiary, but potentially could end up costing the health care system more.

Beyond the immediate impact on beneficiary out-of-pocket costs, redesigning the Medicare benefit will have several other implications:

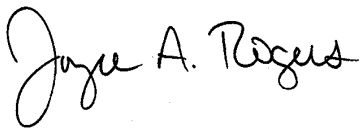
- Depending upon the new cost sharing design, other types of supplemental coverage (e.g., Medigap, TRICARE, VA) will also be affected. It will be important to analyze the interaction of multiple policy changes.
- State Medicaid programs could incur added liability for cost sharing of dually eligible beneficiaries.
- Employer plans that contribute towards the cost of retiree health insurance, which is the most prevalent form of supplemental coverage, could also see added liability.
- A catastrophic cap would put an annual limit on Parts A and B, but would likely be separate from the catastrophic coverage in Part D, and may not apply at all to non-Medicare costs, such as dental, hearing, vision and long term care.

Finally, Congress must consider Medicare benefit redesign in the context of broader reforms to the health care system. Even though redesigning the Medicare benefit package may reduce federal Medicare expenditures, it is likely to result in merely cost-shifting to beneficiaries and other payers,

and do little or nothing to reduce overall health care spending. In fact, Medicare spending growth is already moderating. According to the Congressional Budget Office, from 2007 to 2012, Medicare spending growth has averaged only 1.9 percent per year. In February 2013, the CBO reduced its estimate of projected 2013-2022 spending for the Medicare programs by about $143 billion. Moreover, Medicare spending increased only 0.4 percent per beneficiary in 2012; substantially below the growth in GDP of 3.4 percent per capita. With the rate of Medicare growth stabilizing, to focus solely on Medicare benefits to achieve health care savings misses the larger drivers of health care costs throughout the health care system.

Again, we thank you for holding a hearing to explore Medicare benefit redesign. Medicare reform should be done cautiously and deliberatively, in an effort to minimize impacting the beneficiaries who rely on the program for their health and financial security. If you have any questions, please feel free to call me, or have your staff contact Ariel Gonzalez of our Government Affairs staff at agonzalez@aarp.org or 202-434-3770.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs